		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042325

Facility Name: WESTSHIRE NURSING & REHAB CTR

Address: 5825 W. CERMAK RD. (Number) CICERO (City) 60804 (Zip Code)

County: COOK

Telephone Number: (708) 656-9120 **Fax #** (708) 656-9128

IDPA ID Number: 36-4096965

Date of Initial License for Current Owners: 09/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHELDON NEIDICH
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	411	Intermediate (ICF)	411	150,015	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	485	TOTALS	485	177,025	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,249	1,202	1,127	17,578	8
9	SNF/PED					9
10	ICF	122,487	2,166		124,653	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	137,736	3,368	1,127	142,231	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.35%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 33 and days of care provided 995

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	598,427	53,703	12,150	664,280		664,280	0	664,280			1
2	Food Purchase		551,779		551,779	(41,062)	510,717	(3,020)	507,697			2
3	Housekeeping	366,090	101,892	0	467,982		467,982	0	467,982			3
4	Laundry	143,943	64,903	3,280	212,126		212,126	0	212,126			4
5	Heat and Other Utilities			297,534	297,534		297,534	0	297,534			5
6	Maintenance	198,684	31,382	140,266	370,332		370,332	2,355	372,687			6
7	Other (specify):*			32,269	32,269		32,269	0	32,269			7
8	**TOTAL General Services**	1,307,144	803,659	485,499	2,596,302	(41,062)	2,555,240	(665)	2,554,575			8
	B. Health Care and Programs											
9	Medical Director	0		14,900	14,900		14,900	0	14,900			9
10	Nursing and Medical Records	3,599,771	175,756	12,501	3,788,028		3,788,028	0	3,788,028			10
10a	Therapy	216,342	33	19,359	235,734		235,734	0	235,734			10a
11	Activities	164,705	71,176	7,883	243,764		243,764	0	243,764			11
12	Social Services	196,799		9,030	205,829		205,829	0	205,829			12
13	Nurse Aide Training				0		0	0	0			13
14	Program Transportation			283	283		283	0	283			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	4,177,617	246,965	63,956	4,488,538	0	4,488,538	0	4,488,538			16
	C. General Administration											
17	Administrative	234,239		692,150	926,389		926,389	(507,150)	419,239			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			268,946	268,946		268,946	(48,398)	220,548			19
20	Dues, Fees, Subscriptions & Promotions			190,002	190,002		190,002	(146,086)	43,916			20
21	Clerical & General Office Expenses	344,809	55,311	84,968	485,088		485,088	(3,346)	481,742			21
22	Employee Benefits & Payroll Taxes			906,508	906,508	41,062	947,570	(2,500)	945,070			22
23	Inservice Training & Education			11,127	11,127		11,127	0	11,127			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			581	581		581	0	581			25
26	Insurance-Prop.Liab.Malpractice			448,491	448,491		448,491	102,747	551,238			26
27	Other (specify):* MARKETING	30,011		0	30,011		30,011	(30,011)	0			27
28	**TOTAL General Administration**	609,059	55,311	2,602,773	3,267,143	41,062	3,308,205	(634,744)	2,673,461			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,093,820	1,105,935	3,152,228	10,351,983	0	10,351,983	(635,409)	9,716,574			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR #0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			107,277	107,277		107,277	627,169	734,446			30
31	Amortization of Pre-Op. & Org.			25,619	25,619		25,619	0	25,619			31
32	Interest			91,535	91,535		91,535	1,613,122	1,704,657			32
33	Real Estate Taxes			778,675	778,675		778,675	0	778,675			33
34	Rent-Facility & Grounds			2,004,000	2,004,000		2,004,000	(2,004,000)	0			34
35	Rent-Equipment & Vehicles			122,364	122,364		122,364	0	122,364			35
36	Other (specify):*				0		0	5,180	5,180			36
37	TOTAL Ownership			3,129,470	3,129,470	0	3,129,470	241,471	3,370,941			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		30,872	28,716	59,588		59,588	0	59,588			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			265,537	265,537		265,537	0	265,537			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	30,872	294,253	325,125	0	325,125	0	325,125			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,093,820	1,136,807	6,575,951	13,806,578	0	13,806,578	(393,938)	13,412,640			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21,146)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,020)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(3,346)	21		18
19	Entertainment	0	20		19
20	Contributions	(16,210)	20		20
21	Owner or Key-Man Insurance	(2,500)	22		21
22	Special Legal Fees & Legal Retainers	(53,148)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(129,876)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	(534,806)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (764,052)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	370,114		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 370,114		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (393,938)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WESTSHIRE NURSING & REHAB CTR

ID# 0042325

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2355	6	1
2	MARKETING SALARY	(30,011)	27	2
3	DISALLOWED MANAGEMENT FEES	(507,150)	17	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(534,806)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,020)	0	0	0	0	0	0	0	0	0	0	(3,020)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,355	0	0	0	0	0	0	0	0	0	0	2,355	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(665)	0	0	0	0	0	0	0	0	0	0	(665)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(507,150)	0	0	0	0	0	0	0	0	0	0	(507,150)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(53,148)	4,750	0	0	0	0	0	0	0	0	0	(48,398)	19
20	Fees, Subscriptions & Promotions	(146,086)	0	0	0	0	0	0	0	0	0	0	(146,086)	20
21	Clerical & General Office Expenses	(3,346)	0	0	0	0	0	0	0	0	0	0	(3,346)	21
22	Employee Benefits & Payroll Taxes	(2,500)	0	0	0	0	0	0	0	0	0	0	(2,500)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	102,747	0	0	0	0	0	0	0	0	0	102,747	26
27	Other (specify):*	(30,011)	0	0	0	0	0	0	0	0	0	0	(30,011)	27
28	**TOTAL General Administration**	(742,241)	107,497	0	0	0	0	0	0	0	0	0	(634,744)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(742,906)	107,497	0	0	0	0	0	0	0	0	0	(635,409)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(21,146)	648,315	0	0	0	0	0	0	0	0	0	627,169	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	1,613,122	0	0	0	0	0	0	0	0	0	1,613,122	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(2,004,000)	0	0	0	0	0	0	0	0	0	(2,004,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	5,180	0	0	0	0	0	0	0	0	0	5,180	36
37	**TOTAL Ownership**	(21,146)	262,617	0	0	0	0	0	0	0	0	0	241,471	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(764,052)	370,114	0	0	0	0	0	0	0	0	0	(393,938)	45

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		SOUTHVIEW	CHICAGO	EXTENDED CARE	CHGO	EMPL. LEASING
				WESTSHIRE HEALTH		
				CARE PROPERTIES	CICERO	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 2,004,000			$	$ (2,004,000)	1
2	V	30	DEPRECIATION		WESTSHIRE HEALTH CARE PROPERTIES	100.00%	648,315	648,315	2
3	V	32	INTEREST		WESTSHIRE HEALTH CARE PROPERTIES	100.00%	1,613,122	1,613,122	3
4	V	36	AMORT.-MORT. COSTS		WESTSHIRE HEALTH CARE PROPERTIES	100.00%	5,180	5,180	4
5	V	26	INSURANCE		WESTSHIRE HEALTH CARE PROPERTIES	100.00%	102,747	102,747	5
6	V	19	ACCOUNTING FEES		WESTSHIRE HEALTH CARE PROPERTIES	100.00%	4,750	4,750	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,004,000			$ 2,374,114	$ * 370,114	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON NEIDICH	MEMBER	ADMINISTRATIV	39.59	(southview) $185000	35	63.60	mnmnt fees	$ 185,000	17-8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 185,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WESTSHIRE HEALTH CARE PROPERTIES
Street Address: 5825 W. CERMAK ROAD
City / State / Zip Code: CICERO, IL 60650
Phone Number: (708) 656-9120
Fax Number: (708) 656-9128

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 648,315	$ 0	1	$ 648,315	1
2	32	INTEREST	DIRECT	1	1	1,613,122	0	1	1,613,122	2
3	36	AMORT.-MORT. COSTS	DIRECT	1	1	5,180	0	1	5,180	3
4	26	INSURANCE	DIRECT	1	1	102,747	0	1	102,747	4
5	19	ACCOUNTING FEES	DIRECT	1	1	4,750	0	1	4,750	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,374,114	$		$ 2,374,114	25

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	CAMBRIDGE REALTY OF ILL		X	MORTGAGE	$145,008.00	11/22/99	$ 20,733,500	$ 20,490,686	11/39		$ 1,613,122	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIB BANK		X	WORKING CAPITAL	INTEREST	REVOV		1,000,000	REVOLV	0.0825	57,535	6
7	OMI	X									34,000	7
8												8
9	TOTAL Facility Related				$145,008.00		$ 20,733,500	$ 21,490,686			$ 1,704,657	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 20,733,500	$ 21,490,686			$ 1,704,657	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 644,987	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 711,831	2
3. Under or (over) accrual (line 2 minus line 1).		$ 66,844	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 711,831	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 778,675	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	195,434	8
	1997	601,700	9
	1998	647,367	10
	1999	644,987	11
	2000	711,831	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTSHIRE NURSING & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042325

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-29-202-004-0000	NURSING HOME	$ 99,729.16	$ 99,729.16
2.	16-29-202-005-0000	NURSING HOME	$ 99,729.16	$ 99,729.16
3.	16-29-202-006-0000	NURSING HOME	$ 199,458.45	$ 199,458.45
4.	16-29-202-007-0000	NURSING HOME	$ 113,540.39	$ 113,540.39
5.	16-29-202-008-0000	NURSING HOME	$ 199,373.73	$ 199,373.73
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 711,830.89	$ 711,830.89

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 130,527 B. General Construction Type: Exterior MASONRY Frame _____ Number of Stories NINE STORY

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 0 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 0 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	0		$ 120,000	1
2					2
3	TOTALS			$ 120,000	3

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	485		1996	1972	$ 19,609,780	$ 502,815	39	$ 502,815	$	$ 2,702,631	4
5											5
6											6
7					WESTSHIRE HEALTH CARE PROPERTIES						7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1996	3,490	89	39	89		445	9
10	INSTALLED 13 PHASE			1997	3,440	88	39	88		400	10
11	FURNISHED & INSTALLED GENERATOR FOR ELEVATOR			1997	7,608	195	39	195		886	11
12	NEW HEATER			1997	19,950	511	39	511		2,321	12
13	DRIER VENT MODIFICATIONS			1997	14,985	384	39	384		1,744	13
14	DUCTWORK			1997	9,000	231	39	231		1,049	14
15	INSTALL NEW AMPERS			1997	3,650	94	39	94		427	15
16	TOILETS, SINKS, SHOWER EQUIPMENT			1998	37,587	964	39	964		3,735	16
17	REWIRE 15 ROOMS			1998	10,400	267	39	267		967	17
18	MASTER POWER PANEL, CONTROL			1998	5,994	154	39	154		558	18
19	DOORS			1998	2,941	75	39	75		253	19
20	INSTALL VENTILATION FOR ELEVATOR ROOM			1998	8,750	224	39	224		756	20
21	INSTALL RETURN PIPES & SINKS			1998	4,752	122	39	122		381	21
22	ACCESS PANELS			1998	1,378	35	39	35		109	22
23	DIETARY DOOR & FRAME			1998	2,042	52	39	52		163	23
24	MIXING VALVES			1999	5,000	128	39	128		325	24
25	DRAIN			1999	5,523	142	39	142		361	25
26	WATER METER			1999	8,998	231	39	231		587	26
27	FRAMES,DOORS			2000	10,451	380	27.5	380		586	27
28	EXHAUST FAN & FIRE DAMPERS			2000	4,600	167	27.5	167		258	28
29	BOOSTER PUMP SYSTEM			2000	18,000	655	27.5	655		1,010	29
30	MIXING VALVES			2000	4,215	153	27.5	153		236	30
31	HOT WATER SUPPLY SYSTEM			2001	8,748	172	27.5	172		172	31
32	PAINTING			2001	32,000	630	27.5	630		630	32
33	STORAGE TANK			2001	3,340	66	27.5	66		66	33
34	ELEVATOR REHAB			2001	9,465	187	27.5	187		187	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 19,856,087	$ 509,211		$ 509,211	$ 0	$ 2,721,243	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 779,419	$ 93,710	$ 77,942	$ (15,768)	10 YRS	$ 309,263	71
72	Current Year Purchases	35,855	7,171	1,793	(5,378)	10 YRS	1,793	72
73	Fully Depreciated Assets				0			73
74	REL PARTY	1,455,000	145,500	145,500	0	10 YRS	800,250	74
75	TOTALS	$ 2,270,274	$ 246,381	$ 225,235	$ (21,146)		$ 1,111,306	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 22,246,361	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 755,592	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 734,446	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (21,146)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,832,549	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 79,678 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	SEE ATTACHED		$	$ 42,686	17
18					18
19					19
20					20
21	TOTAL		$	$ 42,686	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 2,786	$		$ 2,786	1
2	Licensed Speech and Language Development Therapist		hrs			186			186	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			25,154			25,154	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				30,872		30,872	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RENTALS						590		590	13
14	TOTAL			$		$ 28,126	$ 31,462		$ 59,588	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 128,192	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,380,366		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	371,356		6
7	Other Prepaid Expenses	18,200		7
8	Accounts Receivable (owners or related parties)	581,032		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,479,146	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	246,307		15
16	Equipment, at Historical Cost	922,928		16
17	Accumulated Depreciation (book methods)	(674,744)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 494,491	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,973,637	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,257,913	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,000,000		29
30	Accrued Salaries Payable	264,114		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,205		31
32	Accrued Real Estate Taxes(Sch.IX-B)	711,831		32
33	Accrued Interest Payable	4,507		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,258,570	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,258,570	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,715,067	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,973,637	$ 0	48

***(See instructions.)**

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,045,582	1
2	Restatements (describe):		2
3	**2000 POST CLOSING ENTRY**	(18,781)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,026,801	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(729,734)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(582,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,311,734)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,715,067	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,073,478	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,073,478	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,608	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,608	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,079	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,079	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	208	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 208	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Unclassified Income	471	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 471	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,076,844	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,596,302	31
32	Health Care	4,488,538	32
33	General Administration	3,267,143	33
	B. Capital Expense		
34	Ownership	3,129,470	34
	C. Ancillary Expense		
35	Special Cost Centers	59,588	35
36	Provider Participation Fee	265,537	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,806,578	40
41	**Income before Income Taxes (line 30 minus line 40)****	(729,734)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (729,734)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,213	2,269	$ 75,395	$ 33.23	1
2	Assistant Director of Nursing	2,238	2,366	63,272	26.74	2
3	Registered Nurses	21,394	23,284	587,006	25.21	3
4	Licensed Practical Nurses	54,874	59,272	1,136,324	19.17	4
5	Nurse Aides & Orderlies	124,387	141,582	1,567,222	11.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,743	12,383	216,342	17.47	8
9	Activity Director	1,960	2,168	35,232	16.25	9
10	Activity Assistants	16,619	18,330	129,473	7.06	10
11	Social Service Workers	15,412	16,309	196,799	12.07	11
12	Dietician					12
13	Food Service Supervisor	4,371	6,435	97,755	15.19	13
14	Head Cook	3,169	4,661	70,803	15.19	14
15	Cook Helpers/Assistants	55,013	59,292	429,869	7.25	15
16	Dishwashers					16
17	Maintenance Workers	12,894	13,627	198,684	14.58	17
18	Housekeepers	36,840	42,706	366,090	8.57	18
19	Laundry	14,985	16,665	143,943	8.64	19
20	Administrator	2,241	2,321	98,461	42.42	20
21	Assistant Administrator					21
22	Other Administrative	2,104	2,240	135,778	60.62	22
23	Office Manager	1,992	2,160	81,605	37.78	23
24	Clerical	21,991	23,728	263,204	11.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,786	3,061	33,338	10.89	31
32	Other Health Ca ward clerks	14,216	15,452	137,214	8.88	32
33	Other(specify) MARKETING	1,448	1,552	30,011	19.34	33
34	TOTAL (lines 1 - 33)	423,890	471,863	$ 6,093,820 *	$ 12.91	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 12,150	1-3	35
36	Medical Director	O	14,900	9-3	36
37	Medical Records Consultant	N	5,091	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,503	10-3	39
40	Physical Therapy Consultant	L	1,913	10a-3	40
41	Occupational Therapy Consultant	Y	2,060	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	690	10a-3	43
44	Activity Consultant	E	7,883	11-3	44
45	Social Service Consultant	E	3,141	12-3	45
46	Other(specify) DENTAL	S	907		46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 55,238		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARY ANN WRIGHT	ADMIN		$ 98,461
ZINA WARD	OP DIRECTOR		135,778
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 234,239

B. Administrative - Other

Description	Amount
OMI-MANAGEMENT FEES	$ 463,150
HUNTER-MANAGEMENT FEES	229,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 692,150
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		268,946
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 268,946

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 122,022
Unemployment Compensation Insurance	33,173
FICA Taxes	464,724
Employee Health Insurance	270,001
Employee Meals	41,062
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	13,368
EMPLOYEE PHYSICAL EXAMS	720
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	2,500
INSURANCE - EXECUTIVE LIFE VI 21	(2,500)
TOTAL (agree to Schedule V, line 22, col.8)	$ 945,070

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	18,148
Health Care Worker Background Check	5,811
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	129,876
TRUST FEES/FRANCHISE TX/ETC	0
CONTRIBUTIONS	16,210
DUES & SUBSCRIPTIONS	12,829
LICENSES & PERMITS	6,928
CONTRIBUTIONS	(16,210)
Less: Public Relations Expense	(0)
Non-allowable advertising	(129,876)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,916

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	6/99	$ 3,518	3 YRS	$	$ 586	$ 1,173	$ 1,173	$ 586	$	$	$	$
2	PAINT/DECORATING	6/00	3,547	3 YRS			591	1,182	1,182	592			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,065		$	$ 586	$ 1,764	$ 2,355	$ 1,768	$ 592	$	$	$

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $11162**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **265,537**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **41,062** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: WESTSHIRE NURSING & REHAB CTR #0042325 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	12,150	
	REPAIRS & MAINTENANCE		0	
			0	12,150
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,280	
			0	3,280
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		99,899	
	ELECTRICITY		138,384	
	WATER		58,642	
	CABLE TV - LOBBY		609	
			0	297,534
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,328	
	PAINTING & DECORATING		1,490	
	BUILDING REPAIRS		9,221	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		76,936	
	ELEVATOR MAINTENANCE & REPAIR		36,244	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		7,122	
	FIRE SERVICE		6,925	
			0	
			0	
			0	140,266
7	**OTHER**			
	SCAVENGER		32,269	
	SECURITY SERVICE		0	32,269
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	14,900	14,900

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	5,091	
	PHARMACY CONSULTANT	XVIII B 39-2	6,503	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		907	
			0	12,501
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		13,037	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		1,659	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,913	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,060	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	690	19,359
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	7,883	
			0	7,883
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		5,889	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,141	
			0	9,030
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR **#0042325** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		283	283
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	692,150	692,150
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	24,594	
	ADMINISTRATIVE CONSULTANTS	XIX C	130,200	
	PROFESSIONAL FEES	XIX C	114,152	
			0	268,946
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	129,876	
	EMPLOYEE WANT ADS	XIX F	18,148	
	CONTRIBUTIONS	VI 20 XIX F	5,790	
	DUES & SUBSCRIPTIONS	XIX F	12,829	
	LICENSES & PERMITS	XIX F	7,128	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	10,420	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	5,811	190,002
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		183	
	EQUIPMENT REPAIR & MAINTENANCE		3,867	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,346	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		4,575	
	TELEPHONE		68,684	
	MESSENGER SERVICE		3,763	
	PARKING PERMITS		550	84,968

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	464,724	
	UNEMPLOYMENT COMPENSATION	XIX D	33,173	
	WORKERS COMPENSATION INSURANC	XIX D	122,022	
	HOSPITALIZATION INSURANCE	XIX D	270,001	
	EMPLOYEE BENEFITS - OTHER	XIX D	13,368	
	EMPLOYEE PHYSICAL EXAMS	XIX D	720	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	2,500	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	906,508
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		11,127	11,127
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		581	581
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		448,491	448,491
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 3,152,228

WESTSHIRE NURSING & REHAB CTR
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	551,779	PATIENT MEALS	426693
LESS SALES TAX	(3,020)	ADD EMPLOYEE MEALS	0
NET FOOD	548,759	TOTAL MEALS/YEAR	426693
TOTAL PATIENT CENSUS	142,231	NET FOOD	548759
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	426693
TOTAL PATIENT MEALS	426693	COST PER MEAL	1.29
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		